

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 6774

**63-048326**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

**FILED DEC 27 1963**

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>1 year</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital Med. Ct.</u>		d. STREET ADDRESS (If outside, give location) <u>1327 Woodland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Williamson</u> Last <u>Williamson</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-98</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baptist Church</u>	
11. BIRTHPLACE (City and state or country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW #1</u>	
16. SOCIAL SECURITY NO. <u>WW #1</u>		17. INFORMANT Address <u>Beatrice Thurman, K. C., Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident, brain stem area with Hyperpyrexia, aphasia, flacid paralysis, coma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>12-2-63</u> <u>12-4-63</u> and last saw her/him alive on <u>12-4-63</u> Death occurred at <u>3:45 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Frank Ellis</u> (Degree or title)		22b. ADDRESS <u>2400 Cherry</u>	
22c. DATE SIGNED <u>12-4-63</u>		23. NAME OF CEMETERY OR CREMATORY <u>National Cem.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>12-18-63</u>	
23c. LOCATION (City, town, or county) <u>Ft. Leavenworth, Kans.</u>		23d. DATE RECD. BY LOCAL REG. <u>12-13-63</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mrs. Meek's Mortuary, K. C., Mo.</u>		25. REGISTRAR'S SIGNATURE <u>Beaie Smith</u>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
MEDICAL CERTIFICATION  
Frank Ellis

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Willard B. Perkins*

Licensed Embalmer No. 5013

P. O. Address K. C. MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.